

7821

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:

COUNTY KENT MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) 4 HRS
 TOWN CHESTERTOWN
 HOSPITAL OR INSTITUTION OR STREET ADDRESS KENT & QUEEN ANN'S HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD. COUNTY KENT
 CITY (If outside corporate limits, write RURAL and give nearest town) KENNEDYVILLE RURAL
 TOWN NEAR LOCUST GROVE
 STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

IVY

ANNE

DAY

4. DATE (Month)

(Day)

(Year)

OF

DEATH:

AUG. 10,

19 55

5. SEX:

FEMALE

COLORED

SINGLE

SEPT. ? 1954.

WIDOWED

DIVORCED

MARRIED

(Specify)

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

NONE

10B. KIND OF BUSINESS OR INDUSTRY:

NONE

11. BIRTHPLACE (State or foreign country):

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

ISIAH

DAY

14. MOTHER'S MAIDEN NAME:

NELLIE MARSHALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.

NONE

17. INFORMANT & ADDRESS:

ISIAH DAY, KENNEDYVILLE, RFD, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

571.0

IMMEDIATE CAUSE

(A)

Acute enteritis (causative organism unknown)

INTERVAL BETWEEN ONSET AND DEATH

4 days

ANTECEDENT CAUSE (S)

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/9, 1955, to 8/10, 1955, that I last saw the deceased

alive on 8/10, 1955, and that death occurred at 4:00 P.M. from the causes and on the date stated above.

SIGNATURE

E. R. W. Jones

M.D.

ADDRESS

Kennedyville, Md

DATE SIGNED

8/10/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BURIAL

AUG 11, 1955

MT. ZION CEMETERY

STILL POND,

MD.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

8/10/55

E. R. W. Jones

B. R. FELLOWS

STILL POND, MD.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

acute ENTERITIS
causative organism
unknown

BUREAU V. S.

AUG 15 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

07830

7325

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Items 2,13,14 FilmG185 8-22-55 et

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Kent STATE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Near Rock Hall		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore 3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 58 Airplane crash in Chesapeake Bay		STREET ADDRESS (If rural, give location) 922 Belgian Avenue ✓	
3. NAME OF DECEASED (Type or Print) Charles Hiram		4. DATE OF DEATH DICKINSON Aug. 7, 1955 19	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 8/24/1932
9. AGE last birthday 22 yrs.		10. UNDER 1 year Months 1 Days 1	11. UNDER 24 hrs. Hours 1 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Camden, N. J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Owens		14. MOTHER'S MAIDEN NAME Catherine Bosch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 562-40-5687	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

863X

Immediate cause

(a) **Injuries, multiple, severe**

INTERVAL BETWEEN ONSET AND DEATH

None

Antecedent cause(s)

Disease or condition(s), if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS

PRIMARY ☒ OR CONTRIBUTING ☐

PLACE OF INJURY

airplane crash
Near

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY **Aug 7 1955 3:20**INJURY OCCURRED
While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

airplane crashed on Chesapeake Bay with no understanding near Rock Hall, Md.22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

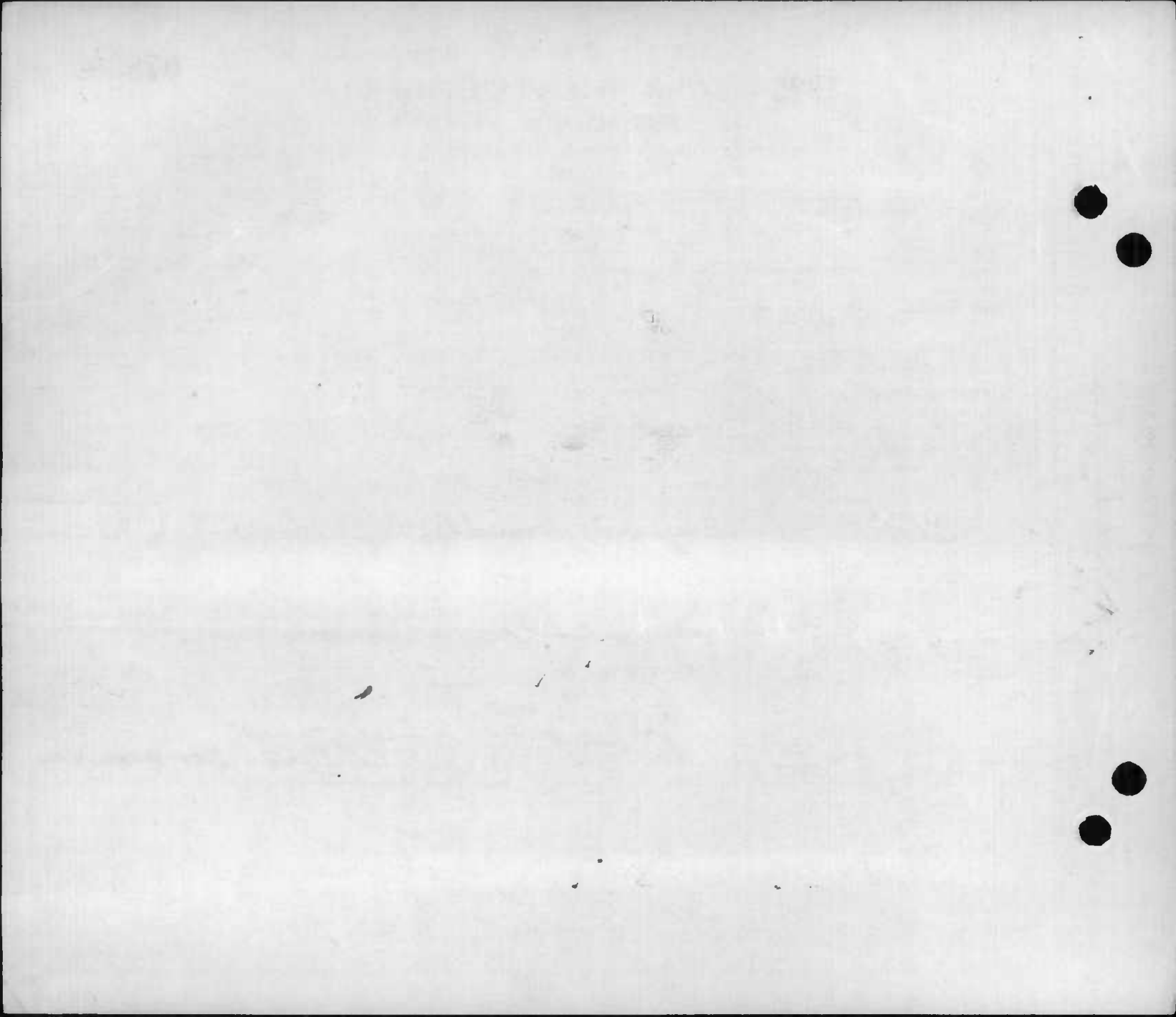
24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



7832

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Keet</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
37 TOWN <u>Chestertown</u>		16 days		OR TOWN <u>Chestertown</u>		17X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
72 <u>Keet & Queen Anne's Hwy</u>				<u>Road top Road</u> ✓			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>B. Walter</u> (Middle) <u>Ferguson</u> (Last)				DATE (Month) (Day) (Year)			
				<u>August 28 1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Married</u>		<u>Sept 21 1884</u>	
						9. AGE last birthday	
						<u>70 yrs</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Retired teacher</u>				<u>Farming</u>		<u>New Jersey</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William Ferguson</u>				<u>Clara Champion</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Unknown</u>				<u>no</u>		<u>Hospital records</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
332X IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>		<u>48 hrs</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arteriosclerosis</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>8-19-55</u>	<u>Enlarged prostate</u>	

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-12, 1954, to 8-28, 1955, that I last saw the deceased alive on 8-28, 1955, and that death occurred at 6:30 P M, from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>		<u>Aug. 31, 1955</u>	<u>Springfield Cem.</u>	<u>Springfield Queens Co. New York</u>
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS
<u>Aug. 29-1955</u>		<u>Clara S. Barnes</u>		<u>J. Willis Wells - Chestertown, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 31 1935

RECEIVED

7826

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY KENT		MARYLAND		STATE MD.		COUNTY KENT	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X WORTON R.F.D.		20 YRS.		WORTON R.F.D.		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
HELEN E. HYNSON				OF DEATH: AUG. 20 1955.			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
FEMALE	NEGRO	MARRIED	JAN. 12, 1898	57 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
HOUSEWIFE				HOME		MARYLAND	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
ANDREW BUTLER				CAROLINE SCOTT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
No				NONE		GILBERT HYNSON WORTON, R.F.D.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
442X IMMEDIATE CAUSE (A) Renal failure						3 weeks	
ANTECEDENT CAUSE (S) (B) Hypertensive Cardiovascular disease						2 + years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cerebrovascular accident							
19A. DATE OF OPERATION:						19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May , 1955, to August , 1955, that I last saw the deceased alive on Aug. 12 , 1955, and that death occurred at 2:45 A.M. , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
Florena Deering Jones		Worton, Md		8/20/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		AUG. 23, 1955		ST. GEORGE'S CEMT		WORTON R.F.D. MD.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
8/22/55		E. Kennard Jones		B. R. FELLOWS		STILL POND, MD.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 26 1955

BUREAU V. 3

7823

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chestertown</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Millington</u>		17X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent + Queen Anne's Hospital</u>				STREET ADDRESS (If rural give location) <u>P.R.#1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Baby Boy Kennedy</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>August 17 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>August 12, 1955</u>	
9. AGE last birthday <u>6</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		<u>6 45</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Walter Elzie Kennedy</u>				14. MOTHER'S MAIDEN NAME: <u>AREZILIA Virginia Massey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mother - Millington, Md. ITR#1</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>6 hrs 45'</u>	
IMMEDIATE CAUSE (A) <u>Unknown</u>							
ANTECEDENT CAUSE (S) DUE TO <u>Was born spent time only after a short labor and with use of minimal amounts of N.O. Did not breathe well at anytime & became extremely agitated when out of oxygen. There was probably some atelectasis. Heart seemed normal clinically & perum & aural</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/17 55</u> , 19 <u>55</u> , to <u>8/17 55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/17 55</u> , 19 <u>55</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>Chastain</u>		ADDRESS <u>Millington Md.</u>		DATE SIGNED <u>ML 8/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>Aug 18, 1955</u>		<u>St. Charles Am.</u>		<u>Pondtown Crumpton Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Aug. 18-1955</u>		<u>Charles S. Barnes.</u>		<u>Edward Yellow</u>		<u>Millington Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 22 1955

RECEIVED

7324

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>KENT.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>KENT.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>37 CHESTERTOWN</u>	LENGTH OF STAY (in this place) <u>22 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>37 CHESTERTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>722 KENTY QUEEN ANNE'S ST.</u>		STREET ADDRESS (If rural give location) <u>102 LYNCHBURG ST.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>GEORGE</u>	(Middle) <u>EDWARD</u>	(Last) <u>LINDSEY</u>	OF DEATH: <u>8 28 1955</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>JUL 5 1909</u>
9. AGE last birthday <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Labourer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Cannery</u>	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME: <u>George Lindsey</u>		14. MOTHER'S MAIDEN NAME: <u>Blanche Johnson.</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE (Yes, no, or unk.) (If Yes, give war or dates of service) <u>UNK.</u>		16. SOCIAL SECURITY No. <u>220-16-9524</u>	
17. INFORMANT & ADDRESS: <u>Hosp. CHART.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>154X</u> <u>INTESTINAL OBSTRUCTION.</u>			<u>2 wks.</u>
ANTECEDENT CAUSE (B) <u>METASTATIC CARCINOMA OF RECTUM,</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. <u>to Mesentery, Liver, Omentum & Small intestine.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>8. 12. 55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Obstruction of Ileum due to metastatic carcinoma</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8. 6, 1955</u> , to <u>8. 28, 1955</u> , that I last saw the deceased alive on <u>8. 25, 1955</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Arthur T. Kasper</u>		DATE SIGNED <u>8. 29. 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9/1/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Rich Neck (col.) Cem.</u>		LOCATION (City, town, or county) (State) <u>near- Church Hill Queen Anne Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Aug. 29-1955</u>		REGISTRAR'S SIGNATURE <u>Clara L. Barnes.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>J. Willis Wells - Chestertown, Md</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 31 1955

BUREAU V. S.

7327

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY KENT		MARYLAND		STATE MD.		COUNTY KENT	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STILL POND		LENGTH OF STAY (in this place) LIFETIME		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STILL POND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS —				STREET ADDRESS (If rural give location) —			
3. NAME OF DECEASED: (First) MAURICE (Middle) PEAKER (Last)				4. DATE (Month) (Day) (Year) OF DEATH: AUG. 17, 1955.			
5. SEX: MALE		6. COLOR OR RACE: Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED SEPT. 15, 1886		8. DATE OF BIRTH: 68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER		10B. KIND OF BUSINESS OR INDUSTRY: FARM HAND		11. BIRTHPLACE (State or foreign country): MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: LEWIN PEAKER				14. MOTHER'S MAIDEN NAME: ROSIE GARRISON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO (If Yes, give war or dates of service) —		16. SOCIAL SECURITY NO.: NONE		17. INFORMANT & ADDRESS: MARTHA PEAKER STILL POND, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 331X Hypertension							
ANTECEDENT CAUSE (S) (B) Cerebral Hemorrhage							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) —							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 15, 1955 to Aug. 17, 1955 , that I last saw the deceased alive on Aug 14, 1955 , and that death occurred at 1400 A.M. from the causes and on the date stated above.							
SIGNATURE E. Kestler		M. D. Rock Hall		DATE SIGNED 8/18/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF AUG. 20, '55		NAME OF CEMETERY OR CREMATORY FOUNTAIN CEMETERY		LOCATION (City, town, or county) (State) WORTON, RURAL, MD.	
DATE REC'D BY LOCAL REGISTRAR 8/18/55		REGISTRAR'S SIGNATURE E. J. J. Jones		24. FUNERAL DIRECTOR B. R. FELLOWS		ADDRESS STILL POND, MD.	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. Kester Rock Hall

1⁴⁰ a. m.

BUREAU V. 3

AUG 26 1955

RECEIVED

7828

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERSReg. Dist. No. 208

07836

1. PLACE OF DEATH - COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>near Rock Hall</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
TOWN <u>near Rock Hall</u>		TOWN <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Airplane crash in Chesapeake Bay</u>		STREET ADDRESS (If rural, give location) <u>4804 Wellington Drive</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary Ann Rodgers</u>		4. DATE OF DEATH <u>8-7-55</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>		8. DATE OF BIRTH <u>Feb. 17, 1935</u>	
9. AGE last birthday <u>20</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Wm. L. Rodgers</u>		14. MOTHER'S MAIDEN NAME <u>Mary Reed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
863X Immediate cause (a) <u>Injuries, multiple, severe</u>		<u>none</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE OF INJURY <u>Chesapeake Bay near Rock Hall Kent, Md.</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Aug 7, 1955 5:15</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>airplane crashed in water during thunderstorm</u>			

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE <u>Robert W. Jan</u> M.D.		DATE SIGNED <u>8/10/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>8-13-55</u>	NAME OF CEMETERY OR CREMATORY <u>Ivy Hill</u>	LOCATION (City, town, or county) (State) <u>Alexandria, Virginia</u>
DATE REC'D BY LOCAL REG. <u>8/13/55</u>	REGISTRAR'S SIGNATURE <u>S. Elwood Burgess</u>	24. FUNERAL DIRECTOR <u>Robert W. Jan</u>	ADDRESS <u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED

AUG 18 1955

BUREAU V. S.

7329

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Kent</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>KENT</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>BETTERTON</u>	<u>1 yr</u>	OR TOWN <u>BETTERTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>—</u>		<u>—</u>	

3. NAME OF DECEASED:			4. DATE (Month) (Day) (Year)		
(First)	(Middle)	(Last)	OF DEATH:		
<u>Ruth Victoria</u>	<u>Wilson</u>		<u>Aug</u>	<u>22</u>	<u>19 54</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	10. IF UNDER 1 YEAR
<u>F</u>	<u>NEGR</u>	<u>M</u>	<u>Feb 12, 1901</u>	<u>54</u> yrs.	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?	
<u>COOK</u>		<u>HOTEL</u>	<u>MD</u>	<u>45</u>	

13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>John S. Wilmore</u>		<u>KATIE BROOKS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u>215-12-6756</u>	
17. INFORMANT & ADDRESS:			
<u>VIVIAN HENDERSON, BETTERTON, MD</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
434.3 IMMEDIATE CAUSE		
(A) <u>acute pulmonary edema</u>		<u>15 min -</u>
DUE TO		
ANTECEDENT CAUSE (S)		
(B) <u>left cardiac decompensation</u>		<u>1 hour</u>
DUE TO		
(C) <u>dead on arrival.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State)	
		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at 2:30 A M, from the causes and on the date stated above.

SIGNATURE		ADDRESS		DATE SIGNED	
<u>Flourence Berenger Joyce</u>		<u>Worton, Md</u>		<u>8/22/55</u>	
M. D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>AUG. 25, 1955</u>		<u>FOUNTAIN CEMETERY</u>	
LOCATION (City, town, or county) (State)					
<u>WORTON (P.F.D) MD.</u>					
24. FUNERAL DIRECTOR		ADDRESS			
<u>B. R. FELLOWS</u>		<u>STILL POND, MD.</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE			
<u>8/24/55</u>		<u>E. Kennard Jones</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 26 1955

RECEIVED